

Alaska Center for Dermatology, P. C.

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Patient Authorization To Disclose Protected Health Information (PHI)

Note: Please fill out each section completely, and inquire if you have any questions. Thank you.

Legal Name of Patient _____ DOB _____

Phone _____ Fax (if applicable) _____

Parent or Legal Guardian (if applicable) _____

• I authorize release of the following:

- All PHI, including confidential
- Specific PHI from services rendered between the dates of _____ and _____.
- Specific PHI listed below

All PHI except confidential selected below*
(Note: While specific confidential PHI will not be included, the information authorized for release may make reference to confidential findings.)

- *Confidential: HIV Test Results
 X-ray Reports Mental Health Treatment Records
 Lab Reports Clinic Notes for Doctors
 Alcohol & Drug Therapy
 Other (please specify): _____

• Purpose of PHI release:

- Transfer of records to another provider
- Insurance
- Personal use
- Legal use

• This authorization is valid for:

- A one-time disclosure for treatment received on or prior to this request.
- A continuing disclosure for treatment received on or prior to this request **and** for any **future** treatment of the type described above, not to exceed 12 months.

I authorize the Alaska Center for Dermatology to release my PHI to:

OR

I authorize the Alaska Center for Dermatology to obtain my PHI from:

I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality. Unless I otherwise revoke this authorization in writing, it will expire either upon receipt of records or 12 months from the date of this authorization. At that time no express revocation shall be needed to terminate my authorization. I hereby release the Alaska Center for Dermatology or _____ (originating facility, if not Alaska Center for Dermatology) from any legal responsibility or liability for disclosures that may arise as a result of the use of the information contained in the PHI released.

Patient (or Legal Guardian) Signature

Date

Office Use Only _____ Initials _____ Date _____